LEGISLATIVE AUDIT DIVISION

M E M O R A N D U M

TO: Legislative Audit Committee Members

FROM: Jim Pellegrini, Deputy Legislative Auditor, Performance Audits

DATE: March 30, 2000

RE: **Follow-up to Performance Audit:**
Medicaid Clinical Laboratory Service Payments
Department of Public Health and Human Services (97P-02)

INTRODUCTION

In November 1997, we presented our performance audit on Medicaid Clinical Laboratory Service Payments to the Legislative Audit Committee. The report made six recommendations to the Department of Public Health and Human Services (DPHHS). We requested and received information from DPHHS on their progress in implementing the recommendations in February 1999. To complete the follow-up project, we interviewed department officials and staff, reviewed changes to written policies and procedures, and reviewed departmental correspondence with the Medicaid fiscal intermediary.

In addition to summarizing the results of our follow-up work, this memo presents background on requirements for reimbursing the federal portion of overpayments and correcting erroneous payments to Medicaid providers.

SUMMARY OF FOLLOW-UP RESULTS

As can be seen in the following table, most of the recommendations are partially implemented. Several of the recommendations stated the department should correct underpayments made to providers, recover overpayments, and return the federal portion of the overpayments made to providers. The department has not implemented those portions of the recommendations.

Recommendation Status	
Implemented	1
Partially Implemented	5
Total	6

BACKGROUND OF MEDICAID CLINICAL LABORATORY SERVICE PAYMENTS

The federal Health Care Financing Administration (HCFA) oversees the Montana Medicaid program and issues guidelines and directives relating to the program. Federal and state guidelines explain federal matching funds will pay for outpatient clinical laboratory services performed by a physician, independent laboratory, or hospital. Clinical laboratory testing includes urinalysis, hematology, and chemistry tests. Physicians utilize clinical laboratory tests to assist in diagnosing and treating ailments. The tests may be performed in an independent laboratory, a physician's office, or a hospital laboratory as an outpatient service.

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Montana's State Plan requires payment for covered lab services under the Montana Medicaid program to be the lessor of the:

- Providers' usual and customary charge
- Medicaid fee schedule (department's fee schedule for laboratory service)
- Medicare fee schedule (National Cap Fee)

Medicaid program payments for clinical lab services cannot exceed the payment recognized by the Medicare program, thus the need for two fee schedules.

Section 6300 of the State Medicaid Manual requires the state not pay more than Medicare would pay for services. Coding requirements regarding payment for clinical laboratory services require certain tests be appropriately grouped together, or bundled, for payment purposes. For clinical laboratory services paid using the Medicare fee schedules, payment for tests submitted individually (unbundled) is greater than payment for bundled services. As a consequence, unbundling of clinical laboratory services results in overpayments.

BACKGROUND ON REQUIREMENTS FOR REPAYMENT OF OVERPAYMENTS

Title 42, Part 433.312, of the Code of Federal Regulations, states DPHHS has 60 days from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the federal share must be refunded to HCFA. The state must refund the federal share at the end of the 60 days whether or not the state recovered the overpayment from the provider. The date of discovery for the overpayments found in our audit is the date of the audit report, November 1997.

Federal requirements allow HCFA to charge the department interest on the overpayments should the department fail to repay the federal portion. We contacted federal officials to determine any consequences to the department for not yet repaying the federal share of the overpayments. Federal officials stated at this time they would not charge the department interest. However, should the department fail to repay the federal portion, HCFA could charge the department interest on the overpayments.

DPHHS officials indicated they have not pursued overpayments because of concerns of the department's position not being upheld during the fair hearings process. DPHHS legal staff noted nationwide, hospital associations are challenging whether new coding and billing standards used in this audit were properly enforced. They also indicated they misunderstood the amount of the overpayment. Page 9 of the report states, based on the results of our testing, "The OIG estimates the department overpaid providers $107,522 during calendar years 1995 and 1996. . . . Of this amount, approximately $74,996 is the federal share of the overpayments." The report then discusses the types of errors found during our testing. The department thought the amounts of the errors discussed in the types of errors sections were the amounts of the overpayments. Our recommendations did not specify the overall amount of the overpayments.

BACKGROUND ON CORRECTION OF UNDERPAYMENTS TO PROVIDERS

Department payment methodologies require the department to correct underpayments made to providers. During our audit we determined 19 hospitals were underpaid 3.23 percent for Medicaid clinical laboratory services submitted by the hospitals. The underpayments resulted because the department incorrectly designated these hospitals as non-sole community hospitals. Most of the payment errors went back to 1987.

Sole community hospital designation is based on factors such as isolated location, weather or travel conditions, or absences of other hospitals in the area. HCFA approves hospitals as sole community after the hospital applies for this designation through the fiscal intermediary for Medicare. In their response to our audit, the department stated they did not know the hospitals were sole community providers because

the hospitals never notified the department of their change in status. Section 46.12.503, ARM, states for Montana Medicaid payments, sole community hospitals are also hospitals with less than 51 beds. Our review showed 17 of the hospitals had less than 51 beds in 1987 and should have been designated sole community hospitals for Medicaid payment purposes during this period.

Our follow-up work showed the department has not corrected the underpayments made to providers for the clinical laboratory services.

FOLLOW-UP FINDINGS

The following sections give the implementation status of each recommendation based on follow-up work performed by the Legislative Audit Division.

Controls to Ensure Unbundling of Services Does Not Occur

During the audit we found the department did not have controls to detect potential laboratory bundling errors. We sampled 150 claims and found errors in 149.

Prior Recommendation #1

We recommend the department:

A. Establish edits which detect potential unbundling of clinical laboratory services.

B. *Collect the overpayments paid to providers and reimburse the federal portion of the overpayments.*

This recommendation is partially implemented.

The department established edits detecting potential unbundling of clinical laboratory services. The department has not collected the overpayments paid to providers and reimbursed the federal portion of the overpayments. However, the department is in the process of formally requesting a repayment waiver from HCFA until the legal questions in the case have been resolved.

Controls to Ensure Sole Community Hospital Reimbursements Are Made at the Correct Percentage

During our testing we reviewed the percentages paid to hospitals. Two hospitals in our sample were paid incorrectly. In reviewing documentation for hospital clarifications, we determined 20 additional hospitals not selected in our sample had been incorrectly paid. One hospital was overpaid and 19 were underpaid.

Prior Recommendation #2

We recommend the department:

A. Develop procedures which ensure hospital designations are correct and updated in a timely manner.

B. Correct underpayments made to providers, recover overpayments to providers, and return the federal portion.

This recommendation is partially implemented.

The department developed procedures to ensure hospital designations are correct and updated in a timely manner. The department has not corrected underpayments made to providers, recovered overpayments to providers, or returned the federal portion. The department agreed to open cost settlements paid to hospitals to resolve the payment errors.

Controls to Ensure Duplicate Payments Are Not Made

We found the department did not have controls to ensure duplicate payments were not made to Medicaid providers for clinical laboratory services. We determined 4 of the 150 claims tested had duplicate

services submitted and paid. We did not determine if claims in addition to our sample had duplicate payments submitted and paid.

Prior Recommendation #3

We recommend the department help ensure duplicate payments are not made for clinical laboratory services by increasing the procedure codes reviewed to detect duplicate payment requests submitted by providers.

This recommendation is partially implemented.
The department formed a committee to review duplicate payment status. The committee met, gathered additional information on duplicate payments, and requested staff be more aware of duplicate payments. Department officials stated it would not be cost-effective to increase the number of procedure codes reviewed.

Controls to Ensure Correct Payment Method Is Used

Audit work showed the department did not have controls to ensure changes in payment methods for clinical laboratory services were paid at the correct rate for 17 procedure codes. Payments for the 17 procedure codes were paid at the wrong rate from July 1, 1995, to at least June 1997.

Prior Recommendation #4

We recommend the department develop procedures to ensure changes to payment methodologies for clinical laboratory services are complete, correct, and implemented in a timely manner.

This recommendation is implemented.
The department developed review procedures to ensure changes in payment methodologies are complete, correct, and implemented in a timely manner.

Controls to the Correct Medicare Fee Schedules Are Used

The department contracts with a private firm to administer payments to Medicaid providers. Personnel of the firm input claims information onto the Medicaid Management Information System (MMIS). Payments are determined by using a fee based on the procedure code. During the audit we determined the department paid Medicaid claims for part of 1995 and 1996 using the previous year's Medicare fee schedules. In most cases, the Medicare fee schedules for calendar years 1995 and 1996 were lower than the previous year, resulting in overpayments to providers. Twenty-four percent of the 150 claims in our sample were paid using the previous year's Medicare fee schedule.

Prior Recommendation #5

We recommend the department:

A. Develop procedures which ensure the Medicare fee schedules are uploaded onto MMIS before January 1 of each year.

B. Correct underpayments made to providers, recover overpayments, and return the federal portion.

This recommendation is partially implemented.
The department developed procedures to ensure the Medicare fee schedules are uploaded onto MMIS before January 1 of each year if the department receives them from HCFA by this time. The department has not corrected underpayments, recovered overpayments, or returned the federal portion.

Medical Review Guidelines

Department staff requested some providers submit medical records for specific claims in our sample to verify the providers did not have a medical reason for the coding on the claim. A coding specialist and

staff with a private firm, both of whom are under contract with the department, reviewed the records. Of the 30 claims reviewed by both reviewers, results differed on 20 claims. Department staff stated they did not provide guidelines to the contractors performing the reviews.

Prior Recommendation #6

We recommend the department:

A. Provide appropriate guidelines to code reviewers.

B. Evaluate claim reviews to ensure federal guidelines are followed.

This recommendation is partially implemented

The department is in the process of changing the language in its contracts with code reviewers to include requirements for reviewers to follow federal guidelines. The department has not developed an evaluation process to ensure federal guidelines are followed.

CONCLUSION

The department implemented our recommendation to develop controls for payment methodologies related to clinical laboratory service payments. The department has not corrected underpayments to providers, collected overpayments, or reimbursed the federal portion which resulted from errors in clinical laboratory service payments. While HCFA is not currently assessing interest, the possibility exists that if the department continues to delay repayment HCFA will assess the department interest on the overpayments.

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